HEALTH INSURANCE CLAIM FORM

READ INSTRUCTIONS BEFORE COMPLETING OR SIGNING THIS FORM

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IDPA USE ONLY

PATIENT & INSURED (SUBSCRIBER) INFORMATION

1. PATIENT'S NAME (FIRST NAME, MIDDLE INITIAL, LAST NAME): Patient H	2. PATIENT'S DATE OF BIRTH: 120670	AGE:	3. INSURED'S NAME (FIRST NAME, MIDDLE INITIAL, LAST NAME):
4. PATIENT'S ADDRESS (STREET, CITY, STATE, ZIP CODE) TELEPHONE NO.:	5. PATIENT'S SEX: MALE ☐ FEMALE ☐		6. INSURED'S ID AND/OR MEDICARE NO. (INCLUDE ANY LETTERS):
	7. PATIENT RELATION TO INSURED: SELF ☐ SPOUSE ☐ CHILD ☐ OTHER ☐		8. INSURED'S GROUP NO. (GROUP NAME) AND/OR MEDICAID NO.: 123456789
9. OTHER HEALTH INSURANCE COVERAGE - ENTER NAME OF POLICYHOLDER AND PLAN NAME AND ADDRESS AND POLICY OR MEDICAL ASSISTANCE NUMBER	10. WAS CONDITION RELATED TO: A. PATIENT'S EMPLOYMENT YES ☐ NO ☐ B. ACCIDENT AUTO ☐ OTHER ☐		11. INSURED'S ADDRESS (STREET, CITY, STATE, ZIP CODE):
12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE (READ BACK BEFORE SIGNING) SIGNED DATE	13. I AUTHORIZE PAYMENT OF MEDICAL BENEFITS TO UNDERSIGNED PHYSICIAN OR SUPPLIER FOR SERVICES DESCRIBED BELOW SIGNED (INSURED OR AUTHORIZED PERSON)		

PHYSICIAN OR SUPPLIER INFORMATION

14. DATE OF ILLNESS (FIRST SYMPTOM) OR INJURY (ACCIDENT) OR PREGNANCY (LMP)	15. DATE FIRST CONSULTED YOU FOR THIS CONDITION	16. HAS PATIENT EVER HAD SAME OR SIMILAR SYMPTOM: YES ☐ NO ☐ CHECK HERE IF EMERGENCY ☐	
17. DATE PATIENT ABLE TO RETURN TO WORK	18. DATES OF TOTAL DISABILITY FROM THROUGH	DATES OF PARTIAL DISABILITY FROM THROUGH	
19. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE (e.g. PUBLIC HEALTH AGENCY)	PROVIDER NUMBER	20. FOR SERVICES RELATED TO HOSPITALIZATION GIVE HOSPITALIZATION DATES ADMITTED DISCHARGED	
21. NAME AND ADDRESS OF FACILITY WHERE SERVICES RENDERED (IF OTHER THAN HOME OR OFFICE)		22. WAS LABORATORY WORK PERFORMED OUTSIDE YOUR OFFICE YES ☐ NO ☐ CHARGES:	
23A. HEALTHY KIDS SERVICES YES ☐ NO ☐	23B. FAMILY PLANNING YES X NO ☐	23C. STERILIZATION/ABORTION YES X NO ☐	23D. PRIOR AUTHORIZATION NUMBER:	23E. T.O.S. *: 1

23F. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY

24. REPEAT	A. DATE OF SERVICE	B. P.O.S. *	C. BRIEFLY DESCRIBE PROCEDURES, MEDICAL SERVICES OR SUPPLIES FURNISHED FOR EACH DATE GIVEN — PROCEDURE CODE (IDENTIFY)	MOD		D. DIAGNOSIS CODE	E. CHARGES	F. DAYS OR UNITS	DELETE
1	020805	3	H0033	U4	Oral Med Admin	PRIMARY 63592	125.00	1	
2	020805	3	76815		Ultra Sound	SECONDARY	80.00	1	
3	020805	3	S0190		RU 486		350.00	1	
4	020805	3	S0191				5.00		
5									
6									
7									

25. SIGNATURE OF PHYSICIAN OR SUPPLIER (I AGREE TO COMPLY WITH THE REQUIREMENTS IN THE CERTIFICATION WHICH APPEARS ON THE REVERSE OF AND IS A PART OF THIS BILL) SIGNED ORIGINAL SIGNATURE REQUIRED DATE 031505	26. ACCEPT ASSIGNMENT (GOVERNMENT CLAIMS ONLY - SEE BACK) YES ☐ NO ☐	27. TOTAL CHARGE 560.00	28. AMOUNT PAID 0.00	29. BALANCE DUE 560.00
30. YOUR PROVIDER NUMBER 370624545001	31. PHYSICIAN'S OR SUPPLIER'S NAME, ADDRESS, ZIP CODE: PLANNED PARENTHOOD OF CITY			
32. YOUR PATIENT'S ACCOUNT NUMBER Example 8	33. YOUR PAYEE NUMBER 1	123 OAK STREET		
34. NUMBER OF SECTIONS 4	35. ORIGINAL DCN	36. ORIGINAL VOUCHER NUMBER	ANYWHERE IL 60001	

37A. TPL CODE	37B. TPL STATUS	37C. TPL AMOUNT	37D. TPL DATE	38A. TPL CODE	38B. TPL STATUS	38C. TPL AMOUNT	38D. TPL DATE

* PLACE OF SERVICE (P.O.S.) AND TYPE OF SERVICE (T.O.S.) CODES ON THE BACK

REMARKS:

Completion mandatory, Ill. Rev. Stat., Ch. 23, P.A. Code, penalty non-payment

Form Approved by the Forms Management Center

IL 478-1032
Form HCFA 1500
ILLINOIS DPA 2360 (R-2-90)